KING COUNTY SUPERIOR COURT
JUVENILE COURT SERVICES
JUVENILE JUSTICE ASSESSMENT TEAM (JJAT)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED JUVENILE INFORMATION

The undersigned authorizes:

1. _____ 2. _____

To exchange information regarding and/or to release the records of:

_____
Juvenile's Name

_____ _____
Date of Birth Health Record Number or Social Security Number

The information and records will be released to:

The Juvenile Justice Assessment Team and Affiliated Agencies
1404 E. Yesler Way, Suite A (Mail Stop: 4G)
Seattle, WA 98122

Phone: 206-205-9737 *Fax:* 206-205-9771
E-mail: william.schipp@kingcounty.gov

The Juvenile Justice Assessment Team and Affiliated Agencies include:
- William Schipp, JJAT Coordinator, and Michael Archer, Psy.D., JJAT Psychologist, King County Superior Court-Juvenile Court Services
- Contracted Mental Health Liaisons from Seattle Children's Home and Therapeutic Health Services
- Chemical Dependency Professionals from WAPI Community Services and Juvenile Court Services

This release covers the following dates: _____ to _____
(If no date is given the last two years of data will be released; if juvenile detention health services are requested, the information from the last detention will be released.)

This request is for the purpose of:

___ Maintaining a continuum of care
____ Coordination of Juvenile Justice Assessment Team services
____ Aiding juvenile's legal process
____ Personal reasons _____
(please specify)
____ Other _____
(please specify)

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Records Requested:

Pursuant to RCW 13.40.480, schools are required to make all student records and information necessary for risk assessment, security classification, or placement available to Juvenile Court Personnel and the Department within three working days.

Education: (check the record(s) to be released)

- ☐ Enrollment Verification
- ☐ Class Schedule and Grades
- ☐ Testing Data
- ☐ Discipline (past, current, pending)
- ☐ Transcripts
- ☐ School Health Record
- ☐ Attendance/Suspension Status
- ☐ Special Education (including current IEP)
- ☐ Credits Earned/Needed to Graduate
- ☐ Illegal Use of Weapons/Violation of School Policy
- ☐ History of violent, or disruptive behavior, gang membership or behavior listed in RCW 13.04.155
- ☐ History of Truancy
- ☐ Any drug or alcohol abuse
- ☐ Other_____ (please specify)

Health: (check the record(s) to be released)
These health records may be used in providing medical treatment, for enrollment with a treatment provider, and for discharge planning.

- ☐ Medical Record
- ☐ Psychiatric care/mental illness
- ☐ Progress in Treatment
- ☐ Urinalysis/Breath Analysis Results
- ☐ History or previous detoxifications/treatment episodes
- ☐ Drug or alcohol abuse diagnosis or treatment
- ☐ Confirmed STD test results and/or treatment
- ☐ Social History: including family information
- ☐ Placement Recommendations
- ☐ Other_____ (please specify)

Other Records Requested: (please check box and specify record)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED JUVENILE INFORMATION

My signature below indicates that I understand the following:

- My records are protected under both federal and state law (Code of Federal Regulations Title 42 and 45 and Washington State confidentiality regulations including RCWs 70.02.030, 71.05 and 70.96A) and cannot be disclosed without my written consent unless otherwise provided for in these regulations.
- I may revoke this authorization in writing at anytime.
- I am entitled to a copy of this authorization form.
- This consent is valid for ninety days unless I indicate otherwise.
- This authorization is to release information for the purpose of assessment, coordination of assessments, treatment planning, or the payment for treatment. If I refuse to sign this authorization a health care entity may not refuse to provide me with treatment, payment, or access to services because I refused to sign.

By my signature below, I, _____ further understand that these records will be utilized and relied upon in the process of completing a mental health assessment, substance abuse assessment (GAIN) , psychological evaluation or referral for psychiatric consultation and information contained in these records may be included in these assessments. The Juvenile Justice Assessment Team will not re-release the specific records requested.

I hereby authorize release of any completed assessment generated by the Juvenile Justice Assessment Team (King County, Seattle Children's Home, Therapeutic Health Services or WAPI Community Services) to any other member of the Juvenile Justice Assessment Team for the purposes of coordinating assessments and to the following individuals only:

Name: _____ Name:_____

Name: _____ Name: _____

Youth's Signature: **_____**

Current date: **_____** ***Authorization expiration date:*** **_____**

Parent/Guardian/Personal Representative Signature: **_____**
Relationship to child: **_____** ***Date:*** **_____**

(Required for children under 13 years of age. Personal representative must verify his/her relationship to the child.)